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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH (DMH)
ASSISTED OUTPATIENT TREATMENT
CANDIDATE REFERRAL FORM
Please fax completed form to (213) 380-3680 or email AOTLAOE@dmh.lacounty.gov
For more information, please contact (213) 738-2440
550 S. Vermont Ave., 10th Floor
Los Angeles, CA 90020

REFERRING PARTY INFORMATION

Name: _____ Relation to Candidate:_____

DOB (required if referring party is a child or cohabitant of Candidate): _____

Agency/Hospital (if applicable): _____ Phone: _____

CANDIDATE INFORMATION

Last Name: _____ First Name:_____

Sex/Gender: ☐ Male ☐ Female ☐ Other: _____ IS # (if applicable): _____ SSN: _____

Height: _____ Weight: _____ Hair Color: _____ Eyes: _____ DOB: _____

Current Living Situation: _____ Phone(s): ( ) _____

Address: _____

Race / Ethnicity: _____ Primary Language: _____

IMMEDIATE SAFETY CONCERNS

Current behaviors including danger to self or others or inability to care for self: (If more space is needed, please attach an additional sheet of paper)	Most concerning behavior you have seen from candidate: (If more space is needed, please attach an additional sheet of paper)

TREATMENT INFORMATION

Reason for belief that candidate is at risk further deterioration: (If more space is needed, please attach an additional sheet of paper)	Reason for belief that candidate has not accepted voluntary treatment: (If more space is needed, please attach an additional sheet of paper)

Do you believe the candidate should currently be in a psychiatric hospital or other locked facility? If so, why? (If more space is needed, please attach an additional sheet of paper)

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TREATMENT INFORMATION	
Psychiatric Problems (if known): (If more space is needed, please attach an additional sheet of paper)	Presence of Significant Medical Problems (if known): (If more space is needed, please attach an additional sheet of paper)
Current Mental Health Treatment (including providers, types of services and compliance with current treatment): (If more space is needed, please attach an additional sheet of paper)	Presence of Substance Abuse: (type, frequency, treatment programs): (If more space is needed, please attach an additional sheet of paper)
Treatment History and Compliance (Did candidate keep appointments? If prescribed, did candidate take medication? Was candidate ever on a conservatorship, if so, when?): (If more space is needed, please attach an additional sheet of paper)	
Did candidate improve with treatment (please describe)? (If more space is needed, please attach an additional sheet of paper)	
History of Psychiatric Hospitalization and/or Incarceration (list dates and locations, if known): (If more space is needed, please attach an additional sheet of paper)	

History or Risk of:	Date(s) or Year(s), if known	Date(s) or Year(s), if known	
Suicide Attempts	☐Yes ☐No _____	Have Police ever been called?	☐Yes ☐No _____
History of Violence	☐Yes ☐No _____	Frequent ER visits	☐Yes ☐No _____

For Administrative Use Only

Date Referral Received

Staff Name:

Action Taken: (for additional information, please add another sheet)